

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005301

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **042**  
**FILED MAR 6 1963**

Primary Registration District No.

1000

Registrar's No.

268

STATE FILE NUMBER

VS 300  
Rev. 4/59

15117

25117

3

4 1

5 1

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7 2

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94204

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11

123-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		c. CITY OR TOWN <b>St. Joseph,</b>	
Length of stay in 1b <b>55yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1314 Joseph</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>Csonka</b> Last <b>Csonka</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1885</b>
9. AGE (last birthday) <b>77 1/2</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (City and state or country) <b>Egris Hungary</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Louis Gavojian</b>		13b. MOTHER'S MAIDEN NAME <b>Unk</b>	
14. NAME OF HUSBAND OR WIFE <b>Peter Csonka</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT Address <b>Pater Csonka</b>	
18. CAUSE OF DEATH (Enter only one cause per item for (a) through (f). Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>[REDACTED]</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>2/15/63</b> to <b>2/23/63</b> and last saw her alive on <b>2/23/63</b> Death occurred at <b>3:15 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Arthur W. Slattery, M.D.</b>		22b. ADDRESS SOCIAL WELFARE BOARD <b>10th &amp; Olive, St. Joseph, Mo.</b>	
22c. DATE SIGNED <b>2/26/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/26/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Olivet Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>			
24. FUNERAL DIRECTOR ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 4, 1963</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Permit issued 2-25-63

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~only~~

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*John E. Rupp*

Licensed Embalmer No. \_\_\_\_\_

3986

P. O. Address \_\_\_\_\_

*H. Joseph Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.